A PROPOSAL TO PROVIDE HEALTHCARE SERVICES TO UNINSURED LOW-INCOME MONTANANS THROUGH AN 1115 MEDICAID WAIVER

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January 2005

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Background on Medicaid HIFA Waivers: For a number of years the federal government has employed the Medicaid 1115 Demonstration Waiver as a vehicle through which to enable states to experiment with new ways of delivering healthcare services. The Health Insurance Flexibility and Accountability (HIFA) Waiver is a new version of the existing1115 Demonstration Waiver authority that gives states greater flexibility in designing Medicaid funded healthcare coverage for low-income people who are uninsured and not currently eligible for full Medicaid healthcare benefits. Unlike the case with most of the Medicaid program, HIFA does not create an entitlement to services for eligible individuals. States can (and do) place an upper limit on both the number people served and the total dollars spent on services under the waiver. In addition to providing greater coverage flexibility, HIFA requires that each waiver outline a strategy for exploring ways to better coordinate publicly funded coverage with private insurance. States can meet the coordination requirement by offering individuals who enroll in the waiver the option to receive assistance with paying monthly premiums for health insurance available through their employer rather than receiving direct public benefits. States are permitted to use HIFA to finance certain existing state-funded healthcare benefits as long as any savings are reinvested in expanded healthcare coverage for low income people who are uninsured. All 1115 Demonstration Waivers, including HIFA waivers, are subject to a "cost neutrality test" requiring that federal expenditures for services provided through the waiver are less than or equal to the projected cost of services to the federal government without the waiver. In addition to the requirement to be cost neutral, states must also negotiate an upper limit on the annual rate of growth of the average per person Medicaid expenditure for those individuals covered during the five-year life of the waiver. The federal government will not participate in any of the cost for services provided to the waiver groups that is above the limit set by the caps. The caps apply only to the groups included in the waiver and in no way limit federal Medicaid expenditures on services provided to eligibility groups that are not included in the waiver.

Highlights of Montana's HIFA Waiver Proposal: The Department of Public Health and Human Services (DPHHS) is preparing the outline of an 1115 HIFA waiver proposal for consideration by the 2005 Montana Legislature. At the heart of the Department's proposal is a plan to free-up state money by using the Medicaid waiver to finance a program of mental health services that is currently state-funded. The plan then reallocates the state's savings to provide Medicaid funded healthcare benefits to several thousand low-income Montanans who are currently uninsured. If the concept is approved by the Legislature, a formal waiver proposal will be developed and submitted to the federal government early in state fiscal year 2006, with a target date for implementation of no later than July 1, 2006.

Important Note: Unfortunately, some people are concerned about the prospect of seeking an 1115 HIFA waiver because of the actions taken by some other states to reduce services to existing Medicaid eligibility groups, or increase cost the sharing requirements for the current Medicaid eligible population, as part of their HIFA waivers. While it is true that the federal government has allowed some states to include those kinds of provisions in their waivers, states are not required to do so, and the DPHHS waiver proposal does not make such changes. Montana's waiver proposal would have no negative impact on existing Medicaid eligibility groups or services. No person or group of people currently eligible for Medicaid in Montana would lose their eligibility because of HIFA. There would be no reduction in the type or amount of services provided to people who are currently eligible for the Montana Medicaid program because of HIFA. The important point to

remember is that each HIFA waiver is unique and must be judged on its own merits. A healthcare advocate probably put it best when she said, "If you've seen one HIFA Waiver, you've seen one HIFA Waiver."

The key components of Montana's proposed waiver include:

1. Funding the Mental Health Services Plan with Medicaid: The proposal secures Medicaid financing for a portion of the state-funded Mental Health Services Plan (MHSP) that currently provides mental health services and pharmacy benefits to approximately 2,200 people per month who have a Severe Disabling Mental Illness (SDMI) but are not eligible for Medicaid. In addition to the existing MHSP mental health services and drug benefit, the waiver will provide MHSP participants who do not have health insurance with the opportunity to choose among three physical healthcare benefit options, including: assistance with the cost of the monthly premium of employer based insurance; payment of the monthly premium for private individual insurance policies; or Medicaid fee-for-service benefits of up to $2,000 per person per year. The uninsured MHSP recipients will receive education and assistance in choosing the most appropriate coverage option given their needs.

2. Using the Savings Created by Funding MHSP with Medicaid to Cover the Uninsured: The Department proposes to use the savings realized from securing Medicaid funding of the Mental Health Services Plan as state match to provide a variety of Medicaid funded healthcare benefit packages designed to address the healthcare needs of several thousand low-income uninsured Montanans, from three different groups. The waiver proposal includes two physical healthcare options: one for children and one for adults. In addition to physical healthcare, the waiver will provide an enhanced mental healthcare benefit designed specifically to meet the needs of SED youths. The actual healthcare benefit packages, and the groups and number of people served under the waiver may change as a result of action by the Legislature and/or the negotiations with the federal government. Currently, the proposed uninsured groups and their individual coverage include:

Proposed Group	Proposed Coverage
●Up to 1,800 uninsured children from families whose incomes are under 150% of FPL.	● A Medicaid funded healthcare benefit that is identical to the one provided by CHIP.
●Up to 300 Seriously Emotionally Disturbed youths, ages 18 through 20, who have incomes under of 150% of FPL, are in transition from children's mental health services and are no longer eligible for Medicaid due to their age.	●Up to three years of a Medicaid funded healthcare benefit that is identical to the one provided by CHIP and a set of specialized transitional behavioral health services designed to meet the needs of this group.
●Up to 600 working parents with incomes under 133% of FPL who are no longer eligible for Medicaid themselves, but whose children continue to be enrolled in Medicaid. Most of the parents are in transition from TANF.	●The choice of one of the same three Medicaid funded physical healthcare options available to MHSP recipients, as described earlier in this document.

3. Funding Montana Comprehensive Health Authority Premium Assistance with Medicaid: DPHHS is working with the staff of the State Auditor's Office to include a provision in the waiver that will provide Medicaid funding for a portion of the existing state-funded Montana Comprehensive Health Association (MCHA) Premium Assistance Program. MCHA Premium Assistance is a source of health insurance for people who have serious medical conditions that cause them to be denied coverage by private health insurers and whose incomes are under 150% of FPL. The savings realized from the Medicaid financing of MHCA would be reinvested in the program to maintain the long-term viability of MCHA Premium Assistance, reduce the program's waiting list, and maintain or increase the level of premium assistance to individual MCHA participants.

4. Developing and Implementing a Medicaid Premium Assistance Pilot Program: In order to meet the HIFA requirement that states pursue ways to better coordinate publicly funded healthcare with private insurance, DPHHS will include a provision to develop and implement a Medicaid Premium Assistance pilot program as part of the waiver. The pilot will measure the impact of providing members of one or more of the HIFA waiver groups with the option to choose to receive assistance with paying the cost of the monthly premium for health insurance that is offered through their employer rather than enrolling in the direct coverage available to their eligibility group under the waiver.

5. Meeting the Waiver Cost Neutrality Requirement: Since 1996 Montana has provided a slightly different package of Medicaid optional services, including a reduced set of dental services, to healthy adults who are enrolled in the TANF program. The policy was implemented through a series of federally approved Medicaid waivers, most recently through an 1115 Demonstration Waiver (a.k.a. the "Basic Medicaid Waiver for Able-Bodied Adults") that was approved in February of 2004. In order to meet the requirement that 1115 waivers be cost neutral to the federal government, the Department will propose that the cost saving provisions of Montana's existing 1115 Basic Medicaid Waiver for Able-Bodied Adults be incorporated into the HIFA waiver. Such a change will enable Montana to use the savings that are currently realized through the existing waiver to offset the increases in cost to the federal government that will result from the expanded services that are called for in the HIFA proposal. The consolidated waiver will provide access to additional federal funding with which to provide healthcare to uninsured low-income Montanans, and do so without the need to resort to additional benefit reductions or other unpopular cost savings measures in order to meet the federal cost neutrality test. The integration of the existing savings with new expenditures could be accomplished either through an amendment of the existing Basic Medicaid Waiver, or as part of a new stand alone 1115 Demonstration waiver.

6. Adopting Mechanisms to Maintain Control of Waiver Spending: The proposal will include limits on the numbers of people served in the waiver and the maximum amount of money the state is obligated to spend on benefits to the eligibility groups covered under the waiver. The proposal will also detail the steps the state may take to reduce expenditures should it appear that there is a risk of exceeding the spending or enrollment limits.

7. Negotiating Reasonable Expenditure Caps: The critical final step in the federal waiver approval process is the negotiation of an average annual per person limit on the growth of expenditures for the eligibility groups covered under the waiver. The Department will ensure that any budget

growth caps required by the federal government are set at reasonable levels that do not expose the state to an unacceptable risk of overspending, and the potential loss of federal funding for expenditures above the budget caps. Montana's existing Basic Medicaid Waiver includes caps of 7.7% per year. The projected annual expenditure growth rate for the adults currently covered under the Basic Medicaid Waiver is about one-half of the 7.7% permitted by the waiver cap for this group. While the potential to provide a significant number of uninsured Montanan's with healthcare benefits is very appealing, if in the end the federal government seeks to impose limits on average growth in expenditures or other requirements that expose Montana to an undue financial risk, the Department will withdraw it's waiver proposal and maintain the existing MHSP services as currently funded.

Total Impact of Montana's HIFA Proposal: If approved by the Montana Legislature and the federal government, the proposed waiver would produce almost $11.0 million dollars per year in additional federal revenue with which to provide Medicaid funded healthcare benefits to several thousand low-income uninsured Montanans. It would do so without creating an open-ended entitlement to services and without the need for the additional state funding beyond the levels that are currently appropriated to the MHSP and MCHA programs. The waiver would also free up state dollars for use as match to fund one-time enhancements to the Medicaid Management Information System (MMIS), some of which are required in order to implement the waiver.

Additional Changes to the Waiver Proposal are Likely to Occur: The proposal outlined in this document reflects the evolution of the Department's thinking over the past year regarding the potential for developing and submitting a Medicaid 1115 Demonstration Waiver for Montana. The proposal has changed substantially during that time. While some of the changes reflect a better understanding of HIFA, the majority of the modifications are the product of an effort by the Department to meld the many values and interests of the groups with a potential stake in this project into a coherent waiver proposal that is both creative and fiscally accountable. It is likely that the waiver will continue to evolve. For example, in the normal course of business it would be reasonable to expect that the Legislature might propose additional changes to the waiver as a result of its deliberations. The probability of changes to the waiver proposal has increased with the passage of Initiative 149. Because some of the potential waiver services and target populations, such as low-income children, are also addressed by I-149, it will be important that the Department and the Legislature ensure that the services funded through an 1115 Waiver, and the new I-149 healthcare expenditures, complement each other.

II. BACKGROUND

Challenge of Providing Healthcare Coverage to the Uninsured:

The large number of citizens without access to public or private healthcare coverage is a vexing problem in states across the county, including ours. A survey of Montana households conducted in 2003 as part of the activities of the Montana State Planning Grant found that 173,000 Montanans, 19% of the state's total population, had no public or private health insurance. At the time of the survey 17% of Montana children were uninsured, one of the highest rates in the U.S. One of the most disturbing findings was the large number of Montanans who were working, but were uninsured either because their employers did not offer health insurance, or the available group or individual coverage was too expensive. For example, forty-three percent of surveyed households with incomes

between 125% and 150% of the Federal Poverty Level (between $22,625 and $27,150 per year for a family of four) did not have health insurance. People seeking ways to provide affordable healthcare to low-income citizens often look to government for the answer. In the past, efforts to address the issue of the large number of uninsured Montanans have included proposals to extend the reach of existing state and federally funded healthcare programs such as Medicaid and the Children's Health Insurance Program (CHIP). When contemplating expansions of Medicaid or CHIP the unique characteristics of each program must be understood in order to make informed policy decisions regarding potential changes to the programs.

Covering the Uninsured through Traditional Medicaid:

Medicaid, a jointly funded state and federal program that is administered by the states, is the primary source of publicly funded healthcare for low-income families with children, people with disabilities and the elderly. Each state participating in the Medicaid program is required to fund a percentage of Medicaid expenditures with state matching dollars. The matching percentage varies by state, based on a federal formula related to changes in average per capita income. Montana's Medicaid matching requirement is relatively low compared to other states, with the federal government paying approximately $.70 of every dollar spent on Medicaid services. While Medicaid specifies a set of mandatory services that must be provided, and eligibility groups that must be served, states have the discretion to add other services, and the option to make more groups of low-income people eligible for the program. However, once a state elects to add an optional eligibility category to its Medicaid program *every person* determined to meet the eligibility criteria for the new group is *entitled to receive all of the Medicaid services* offered by the state for which they have a medical necessity, regardless of the availability of state funding.

The option to extend Medicaid eligibility to additional groups of low-income people, coupled with our state's attractive matching rate, have made expanding Medicaid coverage the subject of many discussions concerning strategies to reduce the number of Montanans without health insurance. Attempts to increase the availability of healthcare coverage by expanding access to the traditional Medicaid program have met with limited success. Most states, including Montana, have been reluctant to add additional Medicaid eligibility groups due, in part, to recent experiences with rapidly increasing Medicaid expenditures, coupled with what seem to be perpetually tight state budgets and persistent revenue shortfalls. Even in better fiscal times, the all or nothing entitlement nature of Medicaid has proven to be a barrier that inhibits the use of the program as a vehicle to provide expanded healthcare. Many policy makers believe that intentionally increasing the number of people eligible for Medicaid has a high probability of producing expenditures that far exceed the estimates on which the original policy initiative and budgets are based. They also know that should Medicaid budget deficits loom they will face the choice of spending additional money that the state may not have, or making painful and unpopular reductions in the quality and quantity of services.

Covering the Uninsured through the CHIP program:

Recent efforts to bring affordable healthcare within the reach of uninsured people with low incomes have focused on the expansion of the Children's Health Insurance Program (CHIP), the jointly funded state and federal program that provides health insurance to low-income uninsured children. CHIP provides comprehensive healthcare coverage, including services such as physician, lab and x-ray, hospitalization, pharmacy and dental. Unlike the Medicaid entitlement, the federal funding for

CHIP comes through an annual capped grant award to each state. In addition to the annual grant award, states may also be eligible to receive a periodic redistribution of a portion of any unexpended funds from the CHIP grants made to other states. Currently, there are over 11,000 children from families with incomes under 150% of the Federal Poverty Level (FPL) enrolled in Montana's CHIP program, at a total annual cost of $16.5 million dollars (FY2004), twenty-percent of which consists of state matching funds. In addition to its obvious value as a source of funding for badly needed healthcare services, one of the most appealing features of the CHIP program from the perspective of state and federal policy makers is the fact that, unlike Medicaid, states are permitted to cap enrollment and clearly limit the amount of money they are obligated to spend on the program. While there continues to be a good deal of interest in, and support for, increasing the number of children covered under CHIP in Montana, the lack of the required 20% state match, coupled with uncertainty regarding the exact level of additional federal grant funds that will be available in the future, have restrained efforts to cover more children by expanding CHIP. While the primary mission of CHIP is clearly to provide a source for healthcare for children from families with low-incomes, federal regulations give states the option to cover parents of children who are enrolled in CHIP as well. If states choose to cover parents in CHIP, federal regulations require that they must then enroll all eligible children who apply. For those seeking ways to provide healthcare coverage for young adults, Montana's age group with the highest percentage of people who do not have insurance, a policy decision to extend eligibility for CHIP to even a small number of parents is very attractive, especially in light of the 80/20 federal and state matching ratio. While the logic behind such a policy may be compelling, the fact that it effectively removes the state's ability to cap enrollment in CHIP would eliminate one of the characteristics of the program that is most appealing to many policy makers.

III. HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABLITY WAIVERS

New Coverage Options Available For The Uninsured Through HIFA Waivers:

Health Insurance Flexibility and Accountability Waiver (a.k.a. HIFA) is a new type of Medicaid 1115 Demonstration waiver that enables state to provide Medicaid funded healthcare to additional groups of low-income people without some of the concerns regarding the Medicaid program requirements that have restricted such expansion in the past. The HIFA waiver program is not the product of a new piece of legislation, but rather a policy initiative by the federal Centers for Medicare and Medicaid Services (CMS) the purpose of which is to encourage states to explore creative ways to expand private and/or public healthcare coverage through proposals that go beyond the all or nothing approach that inhibits the use of traditional Medicaid as a vehicle to address unmet healthcare needs. HIFA places special emphasis on expanding healthcare coverage to currently uninsured individuals with incomes under 200% of the Federal Poverty Level.

While much of what HIFA does is theoretically available under the existing federal 1115 Demonstration Waiver authority, the promotion of this new policy option, with its submission guidelines and expedited review process, sends a clear signal to the states that CMS is open to, and encouraging, proposals that increase the availability of healthcare through the development of unique new benefit packages for optional and non-traditional Medicaid eligibility groups. While Medicaid law currently allows states to provide an extensive array of medical services to a wide variety of eligibility groups, it almost always requires that *all* of the members of each eligibility group receive *all* of the medically necessary services offered by the state's Medicaid program.

Detailed Overview of Medicaid HIFA Waiver Option:

New Flexibility Under HIFA – Among the noteworthy features of the new policy option is the flexibility it gives states to:

1. Design alternative Medicaid benefit packages to meet the unique healthcare needs of some existing and new eligibility groups;

2. Require increased cost sharing for some eligibility groups (e.g. premiums, deductibles and co-payments);

3. Limit or cap the state's financial obligation for services to new eligibility groups; and

4. Provide waiver participants with the option to receive financial assistance to help with the purchase of private insurance that is offered through their employer rather than receiving direct public benefits.

Mandatory Benefits and Eligibility Groups: HIFA *does not allow* states to adjust the benefits or eligibility of the mandatory eligibility groups (low-income aged, disabled, children, etc.) that states are *required* to serve under the Medicaid state plan. HIFA does, however, identify two groups whose benefit packages may be adjusted with a waiver from CMS. They are:

1. Optional Populations: These are waiver eligibility groups that states have the option to cover under Medicaid or "CHIP", *regardless of whether or not they are currently covered.* Examples of potential Optional Populations under a waiver include parents and children with incomes above the federal minimums for Medicaid eligibility. "CHIP" children and their parents are also considered optional populations.

2. Expansion Populations: Expansion Populations are those low-income individuals who are members of groups that are never eligible for coverage under the existing Medicaid or "CHIP" programs. Low-income childless adults are an example of a potential waiver Expansion Population that could never be eligible for Medicaid without a waiver.

Flexible Benefit Packages: States can alter the benefit package offered to the Optional and Expansion eligibility groups included in a waiver. HIFA specifies that benefits for Optional Populations must minimally include hospital, physician, laboratory and x-ray, and well-baby and well-child services. It does not mandate a specific level for these services. Benefits for Expansion Populations must only include basic primary care services from physicians. HIFA allows for increased cost sharing for both the Optional and Expansion Populations in the form of larger co-payments, deductibles and/or premiums.

Cost Neutrality: As is the case with all Medicaid waivers, states must demonstrate that federal expenditures under the proposed waiver will be less than or equal to federal expenditures without the waiver. The state must also demonstrate that the additional cost of serving any proposed Expansion Population will be offset in one of the following three ways:

1. Offsetting Savings - Savings achieved from providing reduced benefits package(s) to existing, *or future*, optional eligibility groups may be used to offset additional spending for new services provided under the waiver;

2. Unused Federal "DSH" Spending Authority – Excess federal Disproportionate Share Hospital (DSH) spending authority may be used to cover the federal share of the additional spending for new services provided under the waiver; and

3. Unused federal "CHIP" Allocation - States may choose to apply any unused portion of their federal SCHIP allocation to offset the federal share of spending for new services provided under the waiver, even if the expenditures are for services to eligibility groups that are not ordinarily eligible for CHIP.

Optional Populations meet the waiver cost neutrality test as long as the average cost to Medicaid for all of their services while enrolled in the waiver is less than the amount Medicaid would have spent had the state exercised its "hypothetical option" to adjust its eligibility standards in order to make all of the members of that Optional Population eligible for Medicaid, and therefore entitled to all of the services provided by the traditional Medicaid program.

Maintenance of Effort Requirement: The waiver may not be used to simply refinance existing state healthcare programs. States wishing to use HIFA to fund services they already provide under state financed healthcare programs will be subject to a Maintenance Of Effort (MOE) requirement. The MOE requires that states maintain their current level of spending on any existing state program that is included in a HIFA Waiver. While states are required to maintain the level of state spending that existed prior to a program's inclusion in the waiver, HIFA does not require that all of the money continue to be spent in the same state program. States have the flexibility to redistribute those dollars as long as they are used to purchase healthcare benefits for low-income people who are uninsured. The MOE precludes states from employing schemes that seek to use HIFA waivers as a vehicle through which to secure Medicaid refinancing for state healthcare programs and then using the savings for purposes other than to increase the number of low-income people with healthcare benefits.

Limits on the Growth of Average Per Person Expenditures for Waiver Groups: One of the federal requirements for securing the approval of all 1115 Waivers, including HIFA waivers, is the negotiation of expenditure limits, or growth caps, for each of the Medicaid populations covered by the waiver. Each mandatory or optional eligibility group included in the waiver is a separate Medicaid Eligible Group or "MEG." The expenditure limits are expressed as an average cost of Medicaid services Per Member Per Month (PMPM) for each waiver MEG. The use of an average cost per month rather than average cost per year is intended to control for the impact of people who are enrolled in the waiver for less than a full 12 months in a single year. The PMPM amount for a waiver MEG for any given year is computed by dividing the total Medicaid expenditures for services to that group during that year by the total number of months in which the members of that MEG were eligible for services. It is not necessary that a person receive services in a month, just that they be eligible to receive them. The following is a formula for computing the average PMPM cost for a waiver MEG:

The Average PMPM for MEG #1 for a waiver year is equal to "A" divided by "B" where:

"A" = Total Medicaid expenditures for services to all members of MEG#1 for a given year of the waiver, and

"B" = Total Member Months of enrollment of all the individuals in MEG#1 for that same waiver year.

As part of the negotiations of the terms and conditions of the waiver, the state and federal government agree on a base year for the purpose of establishing the average PMPM budget caps. The Department then computes, and the federal government agrees to, a PMPM base year cost for each MEG included in the waiver. Finally, the parties agree to annual percentage increases to the average PMPM base year cost for each MEG included in the waiver. These inflated figures become the average PMPM expenditures caps for each MEG for each year of the waiver.

Function of the Waiver Expenditure Caps: The expenditure caps limit the average rate of increase in the annual per member per month cost of Medicaid services for only those MEGs included in each waiver. The growth caps do not apply to Medicaid expenditures for services provided to people from eligibility groups other than the ones included in a waiver. While the budget caps do limit the rate of increase in the average expenditure per person for members of the various waiver MEGs, they do not limit Medicaid spending for the caseload growth related to serving additional people who are determined to be Medicaid eligible from each MEG. Although the caps are stated as an average PMPM expenditure amount for each MEG for each of the five years of the waiver, they are applied as an aggregate growth limit over the life of the waiver that is equal to the sum of each year's allowable percentage increase. In other words, average PMPM expenditure may exceed the annual cap in one waiver year as long as there is reduced spending of an equal or greater amount in other waiver years. The growth caps serve as upper limits on the costs in which the federal government will participate during the life of the waiver. If the average PMPM Medicaid expenditure for a waiver MEG exceeds the cumulative growth cap at the end of the waiver, the state is responsible for 100% of all of the Medicaid expenditures above the cap. Rather than waiting until the expiration of the waiver to recover any federal payments in excess of the expenditure limits, states that appear to be at risk of exceeding budget caps are required to develop plans specifying the actions they intend to take to reduce expenditures to the levels required by the waiver agreement.

Administrative Requirements: As is the case with all 1115 waivers, HIFA waivers are awarded for five-year periods. States are required to collect ongoing evaluation and outcome data. As part of the evaluation, HIFA requires that states document and track the number/percent of their population that is uninsured. CMS has the authority to contract for an independent evaluation of the waiver, but it is not a requirement.

IV. OUTLINE OF MONTANA'S PROPOSAL FOR A HIFA WAIVER

The Department of Public Health and Human Services (DPHHS) will present a proposal to the 2005 Montana Legislature to strengthen community mental health services for adults and provide increased healthcare coverage to uninsured low-income children and adults in Montana through an 1115 Medicaid Demonstration waiver. The Department's proposal is a product of over a year of work in cooperation with staff from the federal Medicaid program, state and federal elected officials, consumer advocacy groups and service providers. The plan originated as one of eighteen

recommendations made in FY2004 by the Public Health Advisory Council that was appointed by Governor Martz and charged with looking at ways to "Re-Design" Montana's Medicaid program.

The Department's proposal for a HIFA waiver has three major components.

1. Secure Medicaid Funding to Strengthen the State Mental Health Services Plan - The core concept underlying Montana's HIFA waiver proposal is to secure federal Medicaid financing for the state-funded Mental Health Services Plan (MHSP). Because the federal government pays approximately $.70 cents of each dollar spent on Medicaid services in Montana, funding MHSP under Medicaid will free up a significant amount of the existing state appropriation for MHSP services. The plan calls for using a portion of the state funds that become available to enhance MHSP mental health services and provide a physical healthcare benefit for MHSP recipients.

2. Provide Medicaid Funded Healthcare Coverage for Low-Income Uninsured Montanans – The second component of the Department's waiver proposal allocates the remaining state money that is no longer required to provide current MHSP services as a result of securing Medicaid funding, for use as the state match necessary to provide Medicaid healthcare coverage for several thousand uninsured low-income children and adults. In essence, the proposal uses Medicaid to maintain and enhance services to MHSP recipients, then reallocates the remaining savings to fund increased healthcare benefits for other uninsured Montanans with low incomes.

3. Secure Medicaid Funding to Strengthen the MCHA Premium Assistance Program - The final component of the Department's proposed waiver is a plan to secure Medicaid funding for a portion of the state program that provides premium assistance to low-income people enrolled in the Montana Comprehensive Health Association (MHCA) program. MCHA is a last resort insurance program for people who are denied insurance because of serious health conditions. The savings generated by securing Medicaid participation in the cost of MCHA Premium Assistance will be used to ensure the continued viability of the program, reduce the out-of-pocket cost to consumers, and/or serve some of the people who are currently on the program's waiting list due to the limited availability of state funding.

V. PLAN TO FUND THE MENTAL HEALTH SERVICES PLAN WITH MEDICAID

Rationale for Funding MHSP under HIFA

There are a number of reasons why securing Medicaid funding for a portion of the existing state-funded MHSP program through a Medicaid HIFA waiver appears to be a realistic option worth pursuing.

1. MHSP Serves People with Low Incomes: HIFA focuses on providing healthcare benefits to people whose incomes are under 200% of the Federal Poverty (FPL). Eligibility for MHSP requires that people have incomes under 150% of FPL.

2. HIFA does not Require an Asset Test: MHSP eligibility criteria do not include an asset test. HIFA eligibility does not require an asset test.

3. The Majority of MHSP Participants are Uninsured: HIFA is aimed at providing healthcare benefits to low-income people who do not have public or private health insurance. Two-thirds of MHSP recipients are uninsured.

4. MHSP Provides Healthcare Services: The existing MHSP pharmacy and mental health therapy benefits are medical services that are generally included in healthcare benefit packages. The intent behind HIFA is to provide healthcare benefits.

5. HIFA Gives States the Ability to Limit Total Expenditures: Currently, every person who meets the MHSP eligibility criteria is not automatically entitled to receive every service offered by the program. Total annual MHSP expenditures are limited to the amount appropriated by the legislature, without a legal requirement to meet all of the need for MHSP services. Unlike the case with the majority of the Medicaid program, services provided under a HIFA waiver are not an entitlement. Waiver expenditures may be capped at a predetermined level established by the state.

6. MHSP is Largely State Funded: Approximately $5.5 million of the MHSP program's $6.8 million dollar FY2004 appropriation is made up of state General Fund and State Special Revenue. Securing Medicaid funding for a portion of the MHSP program through HIFA significantly reduces the amount of state dollars required to provide current level MHSP services. HIFA permits states to leverage federal Medicaid dollars for state healthcare programs as long as the savings are used to provide healthcare benefits to additional low-income people who are uninsured.

Description of the Existing Mental Health Services Plan (MHSP)

Overview of MHSP: The Mental Health Services Plan (MHSP) is a set of state-funded mental health services for low-income adults who are determined to have a Severe Disabling Mental Illness (SDMI) but are not eligible for Medicaid. MHSP services include a limited pharmacy benefit and an array of basic mental health therapy and support services delivered through one of four state-designated Community Mental Health Centers. On average, 2,200 adults receive MHSP services each month. Approximately one-third of these MHSP recipients are enrolled in the Medicare program or have some form of private health insurance, the remaining two-thirds are uninsured. MHSP is a discretionary program that is not required by state or federal law. As a result, each person determined to be eligible for the MHSP program does not automatically have a legal entitlement to receive services. The Addictive and Mental Disorders Division (AAMD) of DPHHS is charged with administering the MHSP program within the funding level appropriated by the legislature, regardless of the demand for services from eligible individuals.

For a detailed description of MHSP services and eligibility criteria see ATTACHMENT A.

Current MHSP Funding: The total FY2004 appropriation for MHSP services was approximately $6.8 million dollars. Based on historical spending patterns, AAMD allocates $3.25 to purchase drugs used in the treatment of severe mental illnesses, while the remaining $3.6 million is allocated to purchase the therapeutic and support services provided by the four Community Mental Health Centers. MHSP is funded with a combination of State General Fund (GF), State Special Revenue (SSR) and federal Community Mental Health Services Block Grant (CMHSBG). The State Special

Revenue is a portion of Montana's share of the proceeds from the national tobacco lawsuit settlement.

MHSP FY2004 Appropriation

GF:	$2,333,385
SSR:	$3,250,000
CMHBG:	$1,250,525
Total:	$6,834,380

Description of Proposed MHSP Services Under a Medicaid HIFA Waiver

The following are descriptions of the impacts the proposed HIFA waiver would have on the quality and quantity of the mental health and other services provided to MHSP recipients:

1. Maintains MHSP Services and Eligibility Criteria while Increasing Funding through Medicaid: Under the proposed waiver there would be no change to the eligibility criteria for, or reduction in the existing services available through, the MHSP program. No one currently eligible for MHSP will lose eligibility under the proposal. The pharmacy benefits, therapies and other mental health services currently available under MHSP will continue to be available under HIFA. In fact, the proposal allocates almost $500,000 per year in additional Medicaid funding with which to provide the existing MHSP services to the people enrolled in the HIFA waiver.

2. Reserves a Portion of Existing MHSP Resources to Serve Non-Waiver MHSP Participants: Approximately one-third of current MHSP participants already have some form of healthcare coverage, either through Medicare or some other private health insurance. Because they are insured this group of people is ineligible for Medicaid funded healthcare services provided through HIFA. In order to ensure that they continue to receive the MHSP drug and therapy services they require, the Department plans to reserve approximately one-third of the current MHSP annual appropriation in order to continue services for MHSP recipients who already have health insurance. The remainder of the appropriation will be used as matching funds in the HIFA waiver.

3. Provides a New Physical Healthcare Benefit for Uninsured MHSP Recipients: One of the requirements of HIFA is to increase the number of low-income people who have health insurance. Approximately 1,500 people, or two-thirds of MHSP participants, are uninsured and as a result eligible for Medicaid funded healthcare through HIFA. In addition to their existing MHSP drug and mental health therapy benefits, Montana's waiver proposal provides uninsured MHSP participants with a physical healthcare benefit. HIFA does not require that the state provide the full Medicaid benefit package available to eligibility groups in its existing Medicaid program. States have the flexibility to provide healthcare benefits that are designed specifically for groups such as MHSP, as long as they meet a minimum set of federal requirements. Because many MHSP recipients are childless adults under the age of 65, and they have not been determined to be disabled by Social Security, they are not eligible for traditional Medicaid. Non-traditional eligibility groups such as MHSP are considered to be "Expansion Populations" under

HIFA. At a minimum states are required to provide members of Expansion Populations with basic primary care, including physician services.

Important Note: Before considering the proposed MHSP physical healthcare benefit, it is important to understand the process that led to the coverage described here. Over the past year there has been a good deal of discussion of what should be included in the MHSP physical healthcare coverage under the waiver. During that time some people have expressed the opinion that in order to be minimally acceptable the Department's proposal must provide a full range of benefits including hospitalization, regardless of what the minimum requirements for a HIFA waiver might be. While DPHHS policy makers share the goal of providing all individuals served by the Department, including the people enrolled in MHSP, with the best and most comprehensive healthcare possible, they must also deal with the reality that the waiver cost neutrality requirements impose a limit on the amount of Medicaid money the state is able to spend on providing services to this group. The Department has tried to balance the desire to provide a broad physical health care benefit, with the reality of an upper limit on the resources available for that purpose in the waiver proposal. The evolution of the MHSP healthcare benefit reflects this balancing act. The initial waiver concept presented to the Public Health Advisory Council provided up to $500.00 per year in Medicaid funded physician and other basic primary care services to each MHSP adult. In response to criticism that the benefit was insufficient and did not include services such as hospitalization, the plan for coverage was revised and the annual cost of the healthcare benefit was increased to almost double the original amount. The revised plan called for identifying one or more private insurance policies or products that the state would purchase for each MHSP recipient who was uninsured. The cost of the insurance would vary based on the age of the individual to be insured, but the average annual cost would be no more than $900 per person. While many people considered the enhanced coverage to be a step in the right direction, others remained unconvinced. In addition to continued concerns about the scope of the benefit, the use of private insurance products rather than a state administered fee-for-service program drew additional criticism. In an attempt to address the new concerns, staff of the Department worked to identify an actuarially sound Medicaid fee-for-service healthcare benefit package for the MHSP population. After expending a great deal of time and energy crafting a variety of fee-for-service plans, staff concluded that the projected cost of a broad-based Medicaid fee-for-service option was well above the level necessary for the waiver to be cost neutral. The proposed MHSP physical health care benefit is the product of the compromises and adjustments described here. While the benefit may be less than some might like, it would be a valuable source of paid healthcare for a group of people who will otherwise be uninsured.

MHSP Physical Healthcare Benefit: The waiver proposal includes a flexible strategy for providing the best physical health care benefits possible to uninsured MHSP recipients within the money that is available. The plan, a blend of the various proposed benefit packages the Department has explored over the past year, provides MHSP recipients with the ability to choose one of three physical healthcare benefit options. It also provides each person with education and assistance in selecting the coverage that best meets their needs. While the three proposed MHSP physical healthcare benefit options provide individuals the choice of different methods and approaches to procuring healthcare, the average per person cost to Medicaid for each option is the same.

The three MHSP benefit options are:

a. Employer Premium Assistance - Uninsured MHSP recipients who work at jobs where their employer offers group health insurance will be given the choice to receive assistance with the cost of the monthly premiums for the employer based group insurance. The level of premium assistance available may vary by individual, but the average amount will not exceed $166.00 per month ($2,000 per year).

b. Individual Private Health Insurance Plans – If employer-based insurance is unavailable, or the individual chooses not to participate, they will have the option to apply for, and enroll in, existing individual private health insurance policies. The cost of monthly premiums for the individual healthcare policies selected by MHSP recipients will be paid by Medicaid as long as the cost is no more than a maximum upper limit established by the Department. The monthly premium upper limit will vary based on the age of the insured individual, but the average of all payments will be no greater than $166.00 per month ($2,000 per year). In addition to paying the premiums of existing insurance benefit plans, the Department will encourage private insurance carriers to develop new physical healthcare insurance options designed specifically to provide coverage to MHSP recipients.

c. Medicaid Individual Healthcare Benefit - If an MHSP recipient cannot secure private insurance, or he or she chooses not to do so, the proposal provides them with the option to receive an annual Medicaid physical health care benefit of up to $2,000 per person. A Medicaid Individual Healthcare Benefit will be established for each eligible person selecting this option. The benefit may be used to reimburse up to $166.00 per month in Medicaid funded healthcare services at the Medicaid fee-for-service rate as long as the individual continues to meet the program eligibility criteria. If an individual receives less than $166.00 in Medicaid reimbursed services in any month, the difference between the $166.00 maximum and the actual Medicaid reimbursement will be added to the following month's benefit. The benefit balance can accumulate as long as the individual continues to be enrolled in MHSP, unless the waiver is modified or terminated. In some ways the Medicaid Individual Healthcare Benefit will act like a medical savings account. It provides access to a range of medical care and services, while reinforcing people who are judicious consumers of healthcare. There is, however, one important difference: should the individual withdraw from the program, or lose their eligibility, any remaining balance of the benefit will remain with the Department. DPHHS is exploring the technological and administrative options and issues associated with operating a system of individual healthcare benefits such as the one described here, including the potential to provide the benefit through some form of debit card. While the Department would prefer to implement the healthcare benefits as part of the existing Medicaid fee-for-service system, if for some reason that is not feasible due to cost, administrative complexities, or unforeseen problems, other administrative options that do not employ Medicaid fee-for-service processes and rates will be explored.

In order to facilitate the most appropriate choices possible, the Department, in cooperation with the four Community Mental Health Centers, will provide education and assistance to MHSP recipients in selecting their healthcare benefit. While the current plan calls for providing every uninsured MHSP participant with a physical healthcare benefit, the proposed waiver will include a provision that allows the Department to limit enrollment in the physical healthcare benefit if

such a step is necessary in order to ensure the continued cost neutrality or fiscal viability of the waiver. The implementation of a cap on enrollment in the Medicaid physical healthcare benefit program would in no way impact the ability of eligible individuals to receive the existing state-funded MHSP pharmacy and therapy benefits. The total cost of the new physical healthcare benefit for MHSP recipients is projected to be approximately $3.0 million per year.

4. Provides Funding for New MHSP Short Term In-Patient Acute Psychiatric Services: While some current MHSP participants experience episodic, acute psychiatric problems that often result in the need for short term in-patient psychiatric treatment, MHSP does not currently offer such a service. In addition to the negative impact on the lives of the people enrolled in MHSP, the lack of an in-patient psychiatric benefit often results in unnecessary admissions to the Montana State Hospital (MSH). In order to better meet the needs of MHSP recipients, and avoid unnecessary admissions to MSH, the Department's HIFA proposal provides a total of $200,000 per year in total Medicaid funding with which to purchase short term, acute in-patient psychiatric care. The Addictive and Mental Disorders Division (AAMD) is in the process of defining the exact nature and scope of these additional services.

5. Reallocates a Portion of the Community Mental Health Service Block Grant to Fund SAAs: An additional benefit of securing Medicaid funding for MHSP is the ability to reallocate a portion of the federal Community Mental Health Service Block Grant (CMHSBG), currently used to fund MHSP services, to address other unmet needs in Montana's community mental health service system. Montana's waiver proposal reallocates $250,000 per year of the CMHSBG funds to assist in the development and operation of the Service Area Authorities (SAAs) and to address other system of care issues. While the exact nature of the mission and role of the SAAs in the mental health services system is still evolving, they are expected to act as focal points for planning, developing and delivering mental health services at the regional and local community levels. The block grant funding is intended to augment and enhance the cooperative efforts being made to implement the SAA concept in Montana by AAMD, consumers, advocates and service providers.

Summary of Positive Impact of the Waiver on Services for People with a Mental Illness

The Department's proposed Medicaid HIFA waiver would enhance the quantity, quality and range of services available to Montanans who have a Severe Disabling Mental Illness. Significant service improvements include:

1. Additional Funding for MHSP – the waiver proposal provides almost $500,000 per year in additional funding for the existing Mental Health Services Plan;

2. A New Physical Healthcare Benefit for MHSP Participants – the waiver creates a physical healthcare benefit for the approximately 1,500 MHSP recipients per month who currently do not have health insurance, at an estimated total cost of $3,000,000 per year;

3. A New Short Term In-Patient Acute Psychiatric Benefit for MHSP Participants – the waiver proposal adds $200,000 per year in Medicaid funding for a new short term in-patient acute psychiatric benefit for MHSP recipients; and

4. Community Mental Health Service Block Grant Funds for Development of SAAs – the waiver reallocates $250,000 in federal Community Mental Health Service Block Grant funds to develop and operate Service Area Authorities and address other system of care issues.

VI. PLAN FOR HEALTHCARE FOR UNINSURED MONTANANS

Because seventy cents of every dollar spent on Medicaid services in Montana comes from the federal government, securing Medicaid funding for MHSP through a HIFA waiver will free up almost $3.0 million dollars in state funds. The previous section describes a plan to reinvest some of these newly available state dollars in expanded mental and physical health services for MHSP recipients. Because HIFA imposes a Maintenance of Effort (MOE) requirement whenever a waiver provides reimbursement for what were previously state-funded programs, any state dollars that are not used to expand or enhance MHSP must be used to provide healthcare benefits to other groups of uninsured Montanans with low incomes. The Department's HIFA waiver proposal reinvests the remaining state dollars no longer required to maintain MHSP to fund healthcare benefits for members of the following three groups of uninsured Montanans:

Group#1: Low-income children who cannot enroll in CHIP because the program is full;

Group#2: Seriously Emotionally Disturbed (SED) youths who are in transition from Medicaid funded children's mental health services to adulthood;

Group#3: Working parents of young children who are attempting to make the transition from Medicaid and TANF to employment, whose children remain eligible for Medicaid.

Uninsured Group#1: Provide Medicaid or CHIP Funded Healthcare to Low-Income Children.

The Need for Additional Funding to Serve Uninsured Low-Income Children: Montana's Children's Health Insurance Program (CHIP) is currently the main source of critically needed healthcare services for approximately 11,000 otherwise uninsured Montana children who are ineligible for Medicaid, but have family incomes under 150% of FPL. Because the enrollment in CHIP is capped, and the program is currently at capacity, eligible children are required to wait until there are openings or additional resources are allocated to the program. Estimates from the Montana State Planning Grant indicate that there may be up to 22,000 uninsured Montana children who are eligible for CHIP or Medicaid, but are not enrolled in either program. While there appears to be a great deal interest in increasing the number of children enrolled in CHIP, there are two issues that must be addressed in order to expand the program.

1. Lack of State Match - In order to increase the number of children enrolled in CHIP the state must pay approximately 20% of the total cost to serve them. Finding a source for the state matching funds necessary to expand any state program, even one as popular as CHIP, is always difficult.

2. Uncertainty Regarding the Availability of Additional Federal Grant Funds – In addition to state matching funds, any expansion of CHIP requires that there be sufficient federal CHIP grant authority to support the additional services. Although Montana currently has a balance of over twenty million dollars in federal CHIP grant funding, it is important to note that the federal share

of projected CHIP expenditures in FY2005 exceeds the amount of that year's annual federal grant award by about a million dollars. A surplus in carry-over funds from the grants for previous years will be sufficient to support the current level of CHIP spending for the foreseeable future. However, without an increase in the annual grant award, or the reallocation of a significant amount of unused federal CHIP funding from other states, the potential for a large expansion of the CHIP program may be limited. While a future increase in the size of the federal grant, and/or a reallocation of funding from other states is likely, the magnitude and timing of any additional funding is less than certain.

Description of Proposed Medicaid Healthcare Benefit for Low-Income Children: Montana's proposed HIFA waiver includes a provision that uses a portion of the state's savings that result from securing Medicaid funding for MHSP as matching funds with which to increase the number of low-income children the CHIP healthcare benefit. The allure of the 80/20 matching rate of the CHIP program is obvious. If the Department determines there is sufficient federal CHIP grant authority available, the waiver proposal will include a plan to increase the number of children served in the existing CHIP program. However, should there continue to be concerns regarding the uncertainty of the availability of enough additional federal CHIP grant dollars, the waiver proposal will include a plan to provide a Medicaid funded healthcare benefit package for uninsured low-income children that is identical to the one provided by the CHIP program. This alternative approach to serving low-income children under a waiver is possible because the state already has the *option* to raise the income eligibility standards for its traditional Medicaid program in order to serve children from families with higher incomes, although for reasons related to the fiscal concerns described earlier in this document it has not done so. The children in the new higher income group are considered an "Optional Populations" under HIFA; as such the state is required to provide them with a minimum set of benefits that is more extensive than one required for Expansion Populations such as MHSP. The coverage provided through Montana's CHIP program is the actuarial equivalent of the health insurance benefit available to state employees, as a result it meets the minimum benefit requirements for Optional Populations served under a HIFA waiver. If the additional healthcare benefit for low-income children is funded through Medicaid, the Department will develop a set of procedures and decision rules to coordinate the referral processes and enrollment procedures of the new coverage option for low-income children with those of the existing CHIP program.

For a complete description of the CHIP healthcare benefit, see ATTACHMENT B.

While the using the Medicaid 70/30 matching rate would reduce the number of children served through the waiver when compared to a direct expansion of the CHIP program, current projections indicate that such a funding switch would still provide sufficient resources to provide a high quality healthcare benefit for up to 1,800 low-income children per year. Should the Department determine that there is sufficient federal CHIP grant funding to directly expand the CHIP program, the amount of additional funding available, and number of children served by the HIFA waiver, could increase significantly.

Regardless of whether the additional services for low-income children are funded through CHIP, or through a Medicaid funded alternative, the waiver will initially retain and use the existing CHIP upper income limit of 150% of FPL when determining eligibility. The Department wants to ensure that it has done everything possible to make families who are already eligible at the existing income standard aware of the healthcare benefits that are available for low-income Montana children before

considering raising the program's income upper limit. The waiver proposal will include a provision that allows the state to increase the income eligibility standard in small increments if the Department is convinced that outreach efforts have succeeded in reaching as many eligible families as is realistically possible and the potential to enroll significant numbers of additional children at the current income level is limited.

Uninsured Group#2: Provide Medicaid Funded Healthcare to SED Youths.

The Need for Physical Health and Transitional Mental Health Services for Older SED Children: Montana currently provides Medicaid funded mental and physical healthcare to 6,000 children who have a Serious Emotional Disturbance (SED) and are under the age of 18. The Department's Child and Family Services Division (C&FSD) acts as legal guardian for some Medicaid eligible SED children, many of which reside in licensed foster care homes. A much smaller group of low-income SED children remain with their natural families, receiving Medicaid funded treatment and therapeutic family services. Finally, a small percentage of children, those with the most serious emotional and behavioral problems, are served in higher cost 24-hour residential treatment facilities or psychiatric hospitals, with the funding coming from Medicaid. One of the significant challenges associated with serving SED children in general, and children who reside in 24-hour treatment programs in particular, is assisting them in making a reasonably smooth transition to adulthood. While the road from being a child to being an adult is a rough one for all of us, it is an especially tough for children who are also dealing with serious emotional problems. Facing the demands and challenges of becoming an adult is made more difficult by the fact that when they turn eighteen, and they no longer qualify for Medicaid as children, many may find that they are also ineligible for Medicaid as adults because they do not meet the Social Security Administration's definition of disabled. Some are ineligible for state-funded adult mental health services under MHSP as well because their condition does not meet the state's definition of a Severe Disabling Mental Illness (SDMI). Increasing awareness of the gap between the mental health systems for children and adults has resulted in a greater emphasis on preparing SED children at an earlier age for the inevitable movement out of children's services. While many SED kids do make a relatively smooth transition to adulthood, many do not. For some of these young people the expectation that they cope with their existing emotional problems without the benefit of the services and supports they counted on as children, and at the same time deal successfully with the additional emotional and practical challenges and expectations that come with being a young adult, is too much to ask. The outlook for such children is not good. Their failure to successfully adapt often results in chronic unemployment, substance abuse, frequent contact with law enforcement agencies and, all too often, eventual incarceration in the corrections system. For some, the loss of mental health services exacerbates their emotional problems to the point where they meet the federal and/or state adult mental disability criteria and are again eligible for publicly funded mental health services. Unfortunately, by the time they are determined to be Medicaid eligible as adults the nature and degree of their emotional problems is often more serious. In addition to the obvious negative impact on their mental health, losing Medicaid eligibility at age 18 typically means that these young men and women no longer have access to public or private physical healthcare benefits as well, and they join the ranks of the uninsured.

Proposed Medicaid Funded Physical and Mental Health Benefit for SED Youths: The Department's HIFA waiver proposal includes a plan to use a portion of the state's savings that result from securing Medicaid funding for MHSP as match with which to provide a group of high risk uninsured SED

youths with a Medicaid funded physical healthcare benefit, and a set of therapeutic and support services designed to assist them in making a successful transition to adulthood. The plan calls for serving up to 300 SED youths per year, at a projected annual total cost of $1.6 million.

In order to be eligible for services under the proposed waiver SED children must:

1. Be age eighteen, nineteen or twenty years old;
2. Receive children's mental health services immediately prior to enrollment in the waiver and no longer continue to be eligible for those services due to their age;
3. Be ineligible for the state's MHSP adult mental health services program;
4. Have incomes under 150% of FPL; and
5. Be uninsured and ineligible for Medicare or Medicaid.

The Children's Mental Health Bureau of the Health Resources Division will administer the new coverage option. In addition to the general eligibility criteria described above, the program will specifically target SED children who are:

1. Turning age 18;
2. Receiving Residential Treatment, Therapeutic Group Care, Therapeutic Family Care, or Foster Care services; and
3. Do not have family or other informal support systems on which to rely.

The staff of the Bureau believes that the majority of the SED waiver participants will be children who have left the children's foster care system, although there will be a small number of children from the juvenile justice system as well. There is also the potential to serve a very small number of children who are not associated with either of those systems. SED children will be eligible for a minimum of one year, and a maximum of three years, of physical and mental health benefits under the waiver. Decisions regarding the continued enrollment of each individual will be based on the results of an annual evaluation of their need for additional services.

Description of Proposed Physical Healthcare Benefit for SED Youths: The Department proposal provides each SED child served under the waiver with a comprehensive Medicaid funded physical healthcare benefit that is identical to the one available through the state's CHIP program. The projected cost of providing the CHIP healthcare benefit to 300 SED children is approximately $600,000 per year.

For a more detailed description of the CHIP healthcare benefit, see ATTACHMENT B.

Description of Proposed Transitional Mental Health Services Benefit for SED Youths: In addition to the CHIP healthcare benefit, the waiver proposal creates a new transitional mental health services benefit specifically designed to help SED children who are leaving the children's mental health system to adjust to life in the community and make a successful transition to adulthood. While the staff of the Children's Mental Health Services Bureau is currently in the process of developing the proposed transitional services package, they expect to include services such as individual or group therapy, care management, prescription drugs, medication monitoring and consultation, mentoring or support groups, and employment supports.
The Department's waiver proposal allocates almost $1,000,000 per year to provide up to 300 SED

youths per year with transitional mental health services.

Note: Some of the SED children in the group targeted by the waiver may already receive services that are similar to some of those contemplated under HIFA through the Department's federally funded Montana Foster Care Independence Program (MFCIP). Under MFICP, children may receive life skills assessments and training, transitional living plan development, and some forms of mentoring. In order to avoid any potential for duplication of effort and expenditures, the Department intends to develop a coordinated plan of benefits to ensure that the most appropriate and cost effective services possible are provided to any SED child who is served by both MFCIP and the HIFA waiver.

Uninsured Group #3: Provide Medicaid Funded Healthcare to Uninsured Working Parents of Medicaid Eligible Children.

The Need for an Extension of Healthcare Benefits for Working Parents of Medicaid Children:
Parents of children who are enrolled in Medicaid risk losing their own eligibility when they become employed and their incomes exceed the eligibility standard for adults in the Family Medicaid eligibility category. In many cases the ineligible parents are working in low-wage jobs where they make too much money to be eligible for Medicaid themselves, but their incomes are low enough to allow their children to remain Medicaid eligible due to the higher family income standards for children. In order to address the obvious disincentive to continued employment that comes with the loss of Medicaid funded healthcare, the federal government permits states to maintain the Medicaid eligibility of adults who are making the transition from Family Medicaid to employment. Montana currently provides two six month periods of Transitional Medicaid to families whose income exceeds the Section 1931 Medicaid eligibility standard.

For a complete listing of the criteria used to determine eligibility for Transitional Medicaid see ATTACHMENT C.

The rationale for providing a period of Transitional Medicaid eligibility is that by extending their Medicaid coverage for up to one year, people will have the time to save enough money to be able to afford to enroll in the group insurance offered through their employer, or some other form of private insurance coverage. Unfortunately, the experience has been that when the year of Transitional Medicaid expires many working parents find themselves uninsured because their employer does not offer group insurance or the group insurance is too expensive, as are most of the available private health insurance policies for individuals. If a need for medical care arises for the working parent, it tends to go unmet. Lack of timely and appropriate medical care often leads to more serious health problems, which in turn lead to voluntary or involuntary loss of employment and the parent's eventual return to Medicaid.

In addition to the obvious benefit of public healthcare coverage on the health and emotional status of a low-income parent who would otherwise be uninsured, there is some evidence that when parents have health insurance there is a positive impact on the health of their children as well. Based on the analysis of data gathered from a study that examined medical service utilization patterns, researchers concluded that if a child is raised in a family where the parent(s) and children both have some form of public or private health insurance, the child will receive more frequent and better medical care than a child raised in a family where only the children have healthcare benefits.

Some people question how realistic it is to expect that people who lose their Medicaid eligibility because they are now working in lower wage jobs will secure private healthcare coverage, even with a year of Transitional Medicaid. These same people argue that if states took advantage of the available option to raise the income eligibility standard for adults in the 1931 Family Medicaid eligibility group, thereby providing these low-income working people with a stable source of healthcare for more than one year, it would increase the likelihood that they would remain healthy, and have the opportunity to secure both a better paying job and private health insurance. Higher incomes and private health insurance also make it more likely that people will be able to leave Medicaid and remain off Medicaid. If it is true that children of insured parents receive more frequent healthcare services, another reason for providing health care benefits to working parents of Medicaid children is the potential for a positive impact on the health and welfare of the children themselves, especially younger children. For some children, providing appropriate and timely medical services will prevent a host of health problems that not only diminish the child's quality of life, but inevitably result in higher Medicaid expenditures as well.

Unfortunately, while there appears to be a subjective case to be made that extending some form of publicly funded healthcare coverage to low-income working parents of Medicaid children may increase the likelihood that they remain in their new jobs, secure private health insurance, avoid a return to Medicaid, and raise healthier children, there is not enough data on the subject on which to base a policy decision to create a new entitlement to Medicaid services in the traditional Medicaid program.

Description of Proposed Medicaid Funded Healthcare Benefit for Working Parents: The Department's proposal for a waiver includes a provision to provide Medicaid funded physical healthcare for up to 600 working parents of Medicaid eligible children per year, at a projected annual cost of about $1.4 million. The Medicaid parents will be able to choose of one of the same three physical healthcare options available to the adult MHSP participants, as described earlier in this document. In order qualify for the Medicaid funded benefits the individual must remain employed, have an income at or below 133% of FPL, remain a Montana resident, and continue to have at least one qualifying child in their care under the age of six. The Human and Community Service Division (HCSD), the division of DPHHS that is responsible for administering the state's Temporary Assistance for Needy Families (TANF) program, is interested in assessing the impact that extending publicly funded healthcare would have on the ability of working Medicaid parents to get and keep jobs, secure private health insurance for themselves and their families, and ensure that their children are as healthy as possible. By including working Medicaid parents of young children as an eligibility category in the proposed HIFA waiver, HCSD will have the perfect vehicle through which to test the impact of providing healthcare coverage to a limited number of people, and do so with a modified benefit package. The Division intends to measure the impact of the policy change by gathering evaluative data such as the percent of people who stay employed, the length of their employment, the number that enroll in private health insurance, as well as the impact of the utilization of preventive healthcare services by, and the health status of, their children. Because people in this waiver eligibility group must be working in order to qualify, and because one of the primary goals of the extended coverage is to assist them to access private insurance, the parents of Medicaid children are a logical group to give the option to choose between either employer insurance premium assistance, private insurance or direct public benefits from the Department.

VII. FUNDING MCHA UNDER A MEDICAID HIFA WAIVER

Description of the MCHA Premium Assistance Program:

The Montana Comprehensive Health Association (MCHA) was created by the Montana Legislature to provide health insurance to people who are uninsurable in the private market due to their medical conditions, and who are also ineligible for public healthcare benefit programs such as Medicaid. During the 2003 Session the Montana Legislature appropriated approximately $700,000 per year in State Special Revenue (SSR) to the State Auditors Office for the implementation of an MCHA premium assistance pilot project providing assistance with the cost of MCHA monthly premiums to Montanans with incomes under 150% of the FPL. In addition to the state dollars, in the past the Auditor's Office receives an annual federal grant of about $1.0 million to support MCHA premium assistance. As of October of 2004 the pilot project was paying 45% of the monthly MCHA monthly premiums for 270 low-income Montanans. Unfortunately, the current appropriation of state and federal funding is not enough to serve all of the people qualified for the program, witnessed by the fact that as of October there were about 40 people on the waiting list. While the number of people receiving premium assistance has been increasing, the average cost of MCHA monthly premiums has increased as well. Faced with steadily increasing costs and a fixed amount of state and federal funding with which to operate the program, the Board of Directors of MCHA was recently forced to reluctantly reduce the level of premium assistance provided to people enrolled in the pilot project from 55% to 45%. Early indications are that the reduction in the level of premium assistance is increasing the rate at which people drop MCHA coverage and again become uninsured. In addition to the challenge of dealing with steadily increasing costs, the long-term viability of MCHA Premium Assistance is made more uncertain by the fact that the future availability of federal grant funds is uncertain.

The federal government has already approved a request from the State of Illinois for a HIFA waiver securing federal funding for low-income people served through the Illinois Comprehensive Health Insurance Program (ICHIP), a program whose mission and operation are very similar to that of MCHA. An initial comparison of MCHA and ICHIP confirms that the two programs have much in common and as a result Montana should consider exploring the potential for funding a portion of MCHA benefits through a federal Medicaid waiver, similar to the one already secured by Illinois.

For a detailed description of MCHA, and a comparison of MCHA to the ICHIP program that was included in the Illinois HIFA waiver, see APPENDIX D.

Description of Method for Funding MCHA Premium Assistance through Medicaid

For the last four months the Department has been working with the State Auditor's Office to determine if it were feasible to, and whether there is interest in, including a provision in the HIFA waiver proposal to provide Medicaid reimbursement for a portion of the MCHA Premium Assistance program. After meeting with the members of the Auditor's staff who administer the program, as well as representatives from Blue Cross and Blue Shield, the organization that manages its day to day operation, and based on the results of a conference call with the MCHA Board of Directors, the consensus was that the option to include MCHA in the waiver appeared to be well worth pursuing. As part of the discussions at least three potential uses were identified for any

additional resources that might be generated as a result of securing Medicaid funding for MCHA. They are:

1. Maintaining or increasing the percentage of the monthly premium that MCHA pays for eligible individuals;

2. Eliminating the current waiting list for MCHA Premium Assistance; and

3. Ensuring the continued financial viability of the MCHA Premium Assistance program.

The Department conducted a more detailed analysis of the potential benefits associates with including MCHA in the waiver using data provided by the Auditor's Office and Blue Cross. The data indicate that about 90% of the 300 people enrolled MCHA Premium Assistance as of October of 2004 would likely qualify for Medicaid funding under HIFA. The 10% who would be ineligible are enrolled in Medicare as well as MCHA and therefore are not uninsured, a HIFA requirement. The most logical way to include MCHA in the HIFA waiver would be to adopt the existing MCHA eligibility criteria, benefit package and operational procedures as part of the waiver. Medicaid would then make the monthly premium assistance payment for all the eligible individuals enrolled in the MCHA waiver eligibility group. The waiver agreement with the federal government would include a maximum number of MCHA eligible people to be served, and maximum amount of money to be spent on MCHA premium assistance under the waiver. The federal government would likely consider the MCHA waiver eligibility group an Expansion Population. The cost of waiver services to the MCHA eligibility group must, therefore, be offset by other savings in the waiver, with a logical source being the Department's existing Basic Medicaid Waiver. The Department and the Auditor's office would enter into an inter-agency agreement detailing the accounting procedures required to be able to use a predetermined portion of the SSR currently appropriated for MCHA as matching funds for Medicaid reimbursement of MCHA services under the HIFA waiver.

Based on its initial analysis of the data available in October, and the ongoing discussions with the MCHA stakeholders, the Department developed a hypothetical example of how an MCHA Premium Assistance waiver option might be implemented. The result of that scenario revealed that including a portion of MCHA in a HIFA waiver could generate approximately $700,000 per year in additional federal Medicaid revenue at no additional cost to the state. The additional federal money could be allocated to address the three options for strengthening MCHA that emerged during discussions with the Auditor's Office and the MCHA. For example:

1. The percentage of the monthly premium paid by the MCHA Premium Assistance program for the 270 people enrolled in the program as of October of 2004, could be restored to the previous level of 55%, or perhaps even increased;

2. The 40 people on the MCHA Premium Assistance waiting list as of October of 2004 could be enrolled in the program; and

3. Approximately $300,000 of the SSR appropriation for premium assistance could be retained to by the Auditor's Office to continue to serve the 30 MCHA enrollees who do not qualify for the waiver, while the balance could be used to ensure the long-term viability of the MCHA Premium Assistance program.

Any plan to include MCHA in the waiver proposal will depend on at least three factors:

1. The exact amount of the State Special Revenue appropriation for MCHA that the Auditor's Office and MCHA Board of Directors determine is available for use as Medicaid match after the other needs of the program are met, including the need to maintain the long-term viability of MCHA premium assistance;

2. Decisions by the MCHA Board and the Auditor's Office regarding policy issues such as increasing the percentage of premium assistance provide by the program and serving people on the MCHA waiting list; and

3. The amount of savings from the Basic Medicaid Waiver that would be available to offset expenditures on services to MCHA enrollees. Should there not be sufficient savings available it may not be possible to include MCHA in the waiver.

In order to gather additional information about the people enrolled in MCHA, staff members from the State Auditor's Office developed a questionnaire, in consultation with the Department and Blue Cross and Blue Shield, for distribution to the program participants. The Department hopes to have a decision regarding how or whether to include MCHA Premium Assistance in the HIFA waiver proposal by the time the Legislature meets in January of 2005.

VIII. PROJECTED BUDGET, COST NEUTRALITY AND GROWTH CAPS

Summary of Projected Expenditures and Revenue Sources under the HIFA waiver:

If the proposal for an 1115 waiver is approved by the Legislature and the federal government, the Department estimates it would generate approximately $11.0 million dollars in additional federal Medicaid revenue per year with which to provide badly needed healthcare benefits to almost 4,000 uninsured Montanans. It would do so without the need for additional state dollars above the amount already appropriated for the Mental Health Services Plan (MHSP) and the Montana Comprehensive Health Association (MCHA).

The tables below provide a general summary comparing the FY2004 appropriation for MHSP and MCHA to the projected annual expenditures and revenue sources for the five-year life of the Department's HIFA waiver proposal. The numbers shown here are rounded and will change should the eligibility groups, services and costs in the current waiver proposal be adjusted.

MHSP AND MCHA APPROPRIATION
FY2004

Service/Group	Number Served	Total Funds	MHBG	GF/SSR	Federal XIX
Current FY2004 MHSP Appropriation:	2,200	$6,830,000	$1,250,000	$5,580,000	$0
Current FY2004 MCHA Appropriation:	300	$700,000	$0	$700,000	$0
Total:	2,500	$7,530,000	$1,250,000	$6,280,000	$0

PROJECTED WAIVER REVENUE AND EXPENDITURES

FY2007

Service/Group	Number Served	Total Funds	MHBG	GF/SSR	Federal XIX
Physical and Mental Health Services/MHSP Recipients:	2,200	$10,770,000	$1,250,000	$3,690,000	$6,080,000
CHIP Benefit and Mental Health Services/SED Youth:	100	$510,000	$0	$150,000	$360,000
Chip Benefit/Low-Income Kids:	1,800	$2,900,000	$0	$870,000	$2,030,000
Physical Healthcare Benefit/Medicaid Parents:	600	$1,260,000	$0	$380,000	$880,000
MCHA Premium Assistance/MHCA Participants:	340	$1,370,000	$0	$700,000	$670,000
One-Time MMIS Enhancements:	0	$5,000,000	$0	$500,000	$4,500,000
Total:	5,100	$21,810,000	$1,250,000	$6,280,000	$14,520,000

FY2008

Service/Group	Number Served	Total Funds	MHBG	GF/SSR	Federal XIX
Physical and Mental Health Services/MHSP Recipients:	2,200	$10,950,000	$1,250,000	$3,790,000	$5,920,000
CHIP Benefit and Mental Health Services/SED Youth:	200	$1,040,000	$0	$310,000	$730,000
Chip Benefit/Low-Income Kids:	1,600	$3,320,000	$0	$790,000	$2,320,000
Physical Healthcare Benefit/Medicaid Parents:	600	$1,310,000	$0	$390,000	$920,000
MCHA Premium Assistance/MHCA Participants:	340	$1,370,000	$0	$700,000	$670,000
One-Time MMIS Enhancements:	0	$3,000,000	$0	$300,000	$2,700,000
Total:	5,000	$20,990,000	$1,250,000	$6,280,000	$13,260,000

FY2009

Service/Group	Number Served	Total Funds	MHBG	GF/SSR	Federal XIX
Physical and Mental Health Services/MHSP Recipients:	2,200	$11,080,000	$1,250,000	$3,820,000	$6,000,000
CHIP Benefit and Mental Health Services/SED Youth:	300	$1,580,000	$0	$470,000	$1,110,000
Chip Benefit/Low-Income Kids:	1,800	$2,990,000	$0	$890,000	$2,090,000
Physical Healthcare Benefit/Medicaid Parents:	600	$1,310,000	$0	$390,000	$920,000
MCHA Premium Assistance/MHCA Participants:	340	$1,370,000	$0	$700,000	$670,000
Total:	5,200	$18,330,000	$1,250,000	$6,280,000	$10,790,000

FY2010

Service/Group	Number Served	Total Funds	MHBG	GF/SSR	Federal XIX
Physical and Mental Health Services/MHSP Recipients:	2,200	$11,210,000	$1,250,000	$3,860,000	$6,100,000
CHIP Benefit and Mental Health Services/SED Youth:	300	$1,610,000	$0	$480,000	$1,130,000
Chip Benefit/Low-Income Kids:	1,600	$2,810,000	$0	$840,000	$1,970,000
Physical Healthcare Benefit/Medicaid Parents:	600	$1,330,000	$0	$400,000	$930,000
MCHA Premium Assistance/MHCA Participants:	340	$1,370,000	$0	$700,000	$670,000
Total:	5,000	$18,330,000	$1,250,000	$6,280,000	$10,790,000

FY2011

Service/Group	Number Served	Total Funds	MHBG	GF/SSR	Federal XIX
Physical and Mental Health Services/MHSP Recipients:	2,200	$11,340,000	$1,250,000	$3,900,000	$6,190,000
CHIP Benefit and Mental Health Services/SED Youth:	300	$1,630,000	$0	$490,000	$1,150,000
Chip Benefit/Low-Income Kids:	1,400	$2,540,000	$0	$760,000	$1,780,000
Physical Healthcare Benefit/Medicaid Parents:	600	$1,450,000	$0	$430,000	$1,020,000
MCHA Premium Assistance/MHCA Participants:	340	$1,370,000	$0	$700,000	$670,000
Total:	4,900	$18,330,000	$1,250,000	$6,280,000	$10,790,000

The following assumptions were used in developing these projections:

1. The amount of the state funds (G.F. and S.S.R.) expended in each year of the waiver must be equal to the amount of the state funding appropriated to MHSP and MCHA in FY2004;

2. The Medicaid and CHIP projections are based on the FY2007 match rates that were used by the Department during EPP to develop the Medicaid and CHIP budgets;

3. The per person cost of the adult physical healthcare package was inflated by 4% per year;

4. The per person cost of the CHIP package was inflated by 3% per year; and

5. The existing MHSP, MCHA, and the new SED services assume a fixed appropriation and therefore they are not inflated.

6. The expenditures and numbers of people served are all rounded.

Details Regarding the Sources of Cost Neutrality for the Department's HIFA proposal

The following are the methods by which the Department believes it will be able to achieve the cost neutrality required of HIFA and all other Medicaid waivers:

Achieving Cost Neutrality for the Proposed Waiver Optional Populations – Three of the five proposed eligibility groups included in the Department's HIFA waiver proposal will likely be considered Optional Populations under HIFA. They are: the parents of Medicaid children with family incomes under 133% of FPL; low-income children with family incomes under 150% of FPL; and, SED children ages 18 through 20 who have lost Medicaid eligibility due to their age. Optional Populations are groups that the state already has the ability to choose to include as a Medicaid eligibility group under current law, although they may not have actually done so. Because Montana currently has the "option" to extend Medicaid eligibility to the members of these three groups, they meet the waiver cost neutrality test as long as the average expenditure for their services under the waiver is less than or equal to the projected average expenditure had they received full Medicaid benefits.

Achieving Cost Neutrality for the Proposed Waiver Expansion Populations - The remaining two proposed eligibility groups included in the Department's HIFA waiver proposal, MHSP participants who are uninsured and the low-income enrollees in the MCHA Premium Assistance program, will likely be considered Expansion Populations by the federal government. Expansion Populations are groups that are not ordinarily Medicaid eligible under any circumstances. The cost of the services for Expansion Populations must be offset in one of three acceptable ways identified by CMS, including: offset the additional expenditures with unused federal DSH authority; offset the additional expenditures with unused federal CHIP authority; or, offset the additional expenditures by providing reduced benefits to, or requiring increased cost sharing of, other Medicaid eligibility groups. Montana's HIFA waiver proposal will include a provision to achieve cost neutrality by capturing savings that are realized through an existing 1115 Demonstration waiver already approved by the federal government and currently operating in Montana, thereby offsetting the increased cost of services to the two waiver Expansion Populations. Montana currently provides a reduced set of

Medicaid benefits to adults in the Family Medicaid eligibility group as part of an approved 1115 Demonstration waiver entitled, "Basic Medicaid Waiver for Able-Bodied Adults". The Basic Medicaid Waiver, which originated in 1996 as part of the state's effort at welfare reform, includes stricter limits on optional services such as dental, eyeglasses, dentures and durable medical equipment for the 1931 Adults enrolled in the Family Medicaid eligibility group. While the restricted services available through the Basic Medicaid Waiver result in lower state and federal Medicaid expenditures, that waiver does not include any provision for new spending on other services or new eligibility groups. As a result, the savings achieved through the Basic Medicaid Waiver are theoretically available to offset any additional spending on the Expansion Populations contemplated in the new HIFA waiver proposal. During negotiations for its renewal in February of 2004, the Department discussed the potential to combine the savings from the Basic Medicaid Waiver as an offset to the new spending which would be included in a yet to be submitted HIFA waiver. At that time the federal Medicaid officials agreed they would "give consideration" to some form of combination of the Basic Medicaid Waiver with expanded healthcare coverage under a HIFA waiver, if such a proposal where submitted in the future. While the exact mechanism for combining the two waiver proposals is unclear, there would appear to be only two options: amend the existing Basic Medicaid Waiver to include the additional populations and services detailed in the HIFA proposal, or terminate the Basic Medicaid Waiver and include its provisions for cost savings in a new HIFA waiver, or perhaps another 1115 Demonstration waiver.

Description of Medicaid Eligible Groups and PMPM Expenditure Caps

MEGs and PMPM Budget Caps in Montana's Proposed HIFA waiver: In addition to the requirement that they be cost neutral, HIFA waivers also include expenditure/budget caps or limits on the average Per Member Per Month Medicaid expenditure for each Medicaid Eligible Group (MEG) included in the waiver. Each mandatory and optional eligibility group included in a waiver is considered to be a separate Medicaid Eligible Group (MEG) for the purpose of establishing cost neutrality and the annual upper limits on waiver expenditures.

See Section III, page 11 of this document for a detailed description of how HIFA computes and uses average PMPM expenditure caps.

The Department anticipates there will be at least three Optional Population MEG groups included in the Montana HIFA waiver proposal that would be subject to average PMPM annual expenditure caps. The waiver proposal also includes a fourth MEG made up of the members of the 1931 Adult Family Medicaid mandatory eligibility group that are currently served through the Basic Medicaid Waiver. The projected MEGs in the new Montana HIFA waiver include:

A group of low-income children;
A group of low-income parents of Medicaid eligible children;
A group of low-income SED youth, ages 18 – 20; and
The group of 1931 Family Medicaid Adults currently served through the Basic Medicaid Waiver.

The annual average PMPM Medicaid expenditure on services for each of the MEGs listed here may not exceed the annual average PMPM expenditure limit for that MEG as it is specified in the waiver. While the average PMPM expenditure limits are expressed as annual limits in the waiver, they are applied as aggregate limits.

The people enrolled in the MHSP and MCHA groups that are eligible to receive waiver services make up the two Expansion Populations that are included in the Department's HIFA waiver proposal. Consistent with the cost neutrality requirement, the total Medicaid expenditure for services to Expansion Populations such as MHSP and MCHA must be absorbed within the average PMPM expenditure cap of the 1931 Adult Family Medicaid MEG that is receiving a reduced set of Medicaid benefits.

IX. ADMINISTRATIVE ISSUES:

The Department has started the process of identifying systems enhancements, staffing and other administrative requirements that would be necessary to implement the waiver proposal as described here.

MMIS Enhancements - The nature and final cost of the modifications to existing computer systems, and the cost of any new system development, will depend on the ultimate decisions that are a made regarding eligibility groups and benefit packages. However, there are several components of the proposed waiver that will clearly require some system changes or system development work, including: the use of a capped Medicaid Healthcare Benefit option to pay for physical healthcare for some members of the MHSP and Medicaid parent eligibility groups; the requirement to include MHSP eligibility information and processes in the Department's new CHIMES Medicaid eligibility system; and, the desire to gather more detailed information about MHSP participants and their services. The waiver proposal includes $800,000 in state funds to be matched at a 90/10 federal and state matching rate in order to provide a total of $8.0 million dollars for enhancements to the Medicaid Management Information Systems (MMIS) over the first two waiver years. Any required system changes that result from the waiver will be funded with the money allocated to MMIS in the proposal. Because the amount of funding set aside for MMIS is significantly more than the cost of any potential systems changes that relate directly to the waiver, the Department is in the process of identifying a series of broader MMIS system changes that are necessary to ensure the continued viability of MMIS as a whole.

Staffing Requirements - Although the Department believes that the majority of the administrative functions required by the waiver could be met with existing staffing levels, there may be the need for a small number of additional staff to do the administrative work necessary to maintain the waiver and to develop and implement the new service options related to private insurance and monthly Medicaid Healthcare Benefits. The Department intends to cover any new administrative and staffing costs within the funding allocated for the enhancement of MMIS.

ATTACHMENT A: MHSP ELIGIBILITY AND SERVICES

MHSP Eligibility: In order to be eligible for MHSP people must meet the diagnostic, behavioral, financial and age criteria specified below. The individual must:

1. Be determined by a Community Mental Health Center (CMHC) to have a Severe Disabling Mental Illness (SDMI) in accordance with the state definition;

2. Have income under 150% of the Federal Poverty Level (FPL);

3. Be currently ineligible for Medicaid; and

4. Be age 18 or older.

MHSP Pharmacy Services: MHSP pays for psychotherapeutic and other drugs that are medically necessary for treatment of mental illness. The program does not pay for drugs that are not related to the treatment of mental illness. The pharmacy benefit is limited to $425 per person per month. MHSP recipients who require medications that exceed the monthly limit are responsible for paying for the additional cost with their own funds. MHSP also requires that recipients make co-payments of $17.00 per prescription for brand name drugs and $12.00 for generic drugs. MHSP reimburses pharmacies at the Medicaid rate for each drug.

MHSP Mental Health Therapeutic Services: In addition to drugs, MHSP benefits include a variety of mental health related therapeutic and support services, including: Targeted Case Management, Licensed Professional Counselor, Social Worker, Mid-Level Practitioners, Psychological Services, Psychiatrist, Physician Laboratory and Community Mental Health Center Services such as Day Treatment and PACT services. All of the MHSP therapeutic services are provided by the four regional CMHCs.

ATTACHMENT B: CHIP HEALTHCARE BENEFIT

Eligibility

- Children until age 19
- Montana residents
- US citizens or qualified aliens
- Not currently insured or covered by health insurance in the past 3 months (some employment-related exceptions apply)
- Not eligible for Medicaid
- Parents not employed by the State of Montana
- Household meets income guidelines (see chart below)

There are no asset or resource tests.

Co-payments

- Some families will pay a small co-payment when services are received.
- No co-payment for well-baby or well-child care, including age-appropriate immunizations
- No co-payment for dental services
- $25 each inpatient hospital visit
- $5 each emergency room visit
- $5 each outpatient hospital visit
- $3 each physician visit
- $3 each generic prescription drug
- $5 each brand-name prescription drug

The maximum co-payment for a family is $215 per family per benefit year(Oct.1 through Sept. 30).

Services Covered

- Physician, Physician Assistants and Advance Practice Registered Nurses
- Inpatient and outpatient hospital services
- Routine sports or employment physicals
- General anesthesia services
- Surgical services
- Clinic and ambulatory health care services
- Prescription drugs
- Laboratory and radiological services
- Inpatient, outpatient, and residential mental health services
- Inpatient, outpatient, and residential substance abuse treatment services
- Dental services
- Vision exams
- Eyeglasses
- Hearing exams

ATTACHMENT C: TRANSITIONAL MEDICAID ADULTS ELIGIBILITY

Transitional Adults are those adults who have received Section 1931 Medicaid for at least three of the six months immediately preceding closure of Section 1931 Medicaid due to a qualifying event.

A qualifying event is when Section 1931 Medicaid coverage closes due to new or increased earned income of the assistance unit. Transitional Medicaid (TMA) is broken into two six-month periods.

For the first six months of TMA, the family must:

1. Contain at least one qualifying child,
2. Maintain Montana residency, and
3. Continue to cooperate with Child Support Enforcement Division.

For the second six months of TMA, the family must:

1. Contain at least one qualifying child,
2. Maintain Montana residency,
3. Continue to cooperate with Child Support Enforcement Division
4. Continue to be employed or have good cause for loss of employment,
5. Have countable income equal to or less than 185% FPL and
6. Meet TMA reporting requirements (complete and submit quarterly reports in the fourth, seventh and tenth months of TMA coverage).

ATTACHMENT D: OVERVIEW OF MCHA

Executive Summary: The Montana Comprehensive Health Association (MCHA) was created by the Montana Legislature to provide health insurance to people who are uninsurable in the private market due to their medical conditions, and who are also ineligible for public health care benefit programs such as Medicaid. The federal government recently approved a request from the state of Illinois for a waiver to federal Medicaid and S-CHIP regulations that enabled them to secure federal funding for low income people served through the Illinois Comprehensive Health Insurance Program (ICHIP), a program whose mission and operation appear to be very similar to that of MCHA. An initial comparison of MCHA and ICHIP confirms that the two programs have much in common and as a result Montana should consider exploring the potential for funding a portion of MCHA benefits through a federal Medicaid waiver, similar to the one already secured by Illinois.

Montana Comprehensive Health Association (MCHA): In 1985 the Montana Legislature created the Montana Comprehensive Health Association (MCHA) to establish a program through which health insurance could be made available to Montana residents who are otherwise considered uninsurable due to medical conditions. MCHA serves those Montanans who are not part of the traditional health insurance market because of a preexisting health condition or a significant exclusion of coverage. MCHA provides coverage of "last resort" and is not intended to duplicate coverage from any other source, public or private. MCHA is a private entity, governed by a board of directors made up of five representatives of health insurance carriers doing a high volume of business in Montana, two members-at-large and a public interest member. Coverage under MCHA is administered by BlueCross BlueShield of Montana. The first MCHA policies, currently referred to as the Traditional Plan, were issued in 1987. In 1997, in response to new federal legislation, the Montana Legislature added the MCHA Portability Plan for individuals who lose employer coverage. Both plans offer consumers the choice of two options that require different deductibles, co-pays and out-of-pocket maximums.

MCHA Premium Assistance Pilot Program: In September, 2002 MCHA implemented a "pilot program" providing subsidized premium assistance for persons who qualify for the MCHA Traditional Plan and have family income at or below 150% of federal poverty level. The pilot program provides the same benefits as the MCHA Traditional Plan, Option A. The premium subsidy is 65% of premium during the preexisting condition waiting period and 55% after the waiting period has been fulfilled. Pilot program features include: an annual deductible of $1,000; a 20 percent co-payment; maximum deductible and co-payment expenses during a calendar year of $5,000; and a lifetime coverage maximum of $1,000,000. As of April, 2004 approximately 190 people are insured through the premium assistance pilot program.

MCHA Premium Assistance Benefits: The Premium Assistance Pilot Program(Traditional Plan, Option A) requires a $1,000 deductible, 80/20 co-payment, with a $5,000 out of pocket limit. Coverage includes:

inpatient hospital care
durable medical equipment($5,000 max)
outpatient hospital care
home healthcare(180visits/year)
professional services
immunizations
severe mental illness
rehabilitation therapy
office visits
prosthetics
well child care (up to 24 months)
newborn & adopted child.(31 days)
convalescent home care (60 days)

lab and x-ray
prescription drugs
Office visits
ambulance
radiation and chemotherapies
maternity
maternity screening, program
mammography
diabetes education
surgery and anesthesia

transplants ($150,000)

Historical MCHA Funding: Prior to the last legislative session, MCHA had three sources of revenue from which to pay claims:

1. An annual one percent assessment on the total amount of all premiums paid to each of the health insurance carriers doing business in Montana by the people they insure - currently about $5 million per year;

2. The monthly premiums paid to MCHA for health care coverage by insured participants, and

3. A federal grant to be used to fund premium assistance provided through the MCHA pilot program.

Appropriation of State Funds for MCHA by the 2003 Legislature: The 2003 Montana Legislature appropriated $1,360,563 in State Special Revenue from tobacco settlement proceeds to the Montana State Auditor's Office to help fund the Montana Comprehensive Health Association for the coming biennium. The money is currently being used to pay for premium assistance and/or other health care claims paid by MCHA.

Illinois Comprehensive Health Insurance Plan (ICHIP): The Illinois Comprehensive Health Insurance Plan (ICHIP) provides access to health insurance coverage for certain eligible Illinois residents who have been denied major medical coverage because of their health by private insurers, and to serve as an acceptable alternative mechanism for complying with the individual portability requirements of the federal Health Insurance Portability and Accountability Act (HIPAA). The ICHIP program is governed by a board of directors, the membership of which is defined in Illinois state law, and administered by Blue Cross and Blue Shield of Illinois. The program is funded partly by premiums paid by its participants and, to the extent that premiums do not meet anticipated expenses, by an appropriation from the State's General Revenue Fund and an assessment of all health insurers doing business in the State of Illinois. There are several ICHIP plans available. Premiums vary by gender, age, geographic area, deductible amount ($500, $1,000, $1,500 or $2,500), and type of plan.

Illinois ICHIP Waiver: In 2002, the federal government approved a request from the state of Illinois for a Medicaid Waiver under the Health Insurance Flexibility and Accountability (HIFA) initiative from the Centers for Medicaid and Medicare Services (CMS). Among other things, the waiver secured

federal funding for health care services provided to some low income individuals served through the Illinois Comprehensive Health Insurance Program.

The descriptions of the ICHIP population and services that follow are taken directly from the "Special Terms and Conditions" that accompanied the Illinois waiver approval letter from CMS:

ICHIP Participants: "ICHIP program participants" are defined as participants in the Illinois Comprehensive Health Insurance Program with net incomes from 0 percent and up to and including 185 percent of the Federal Poverty Level (FPL) who are uninsurable and, by definition, do not have coverage under a group health plan or health insurance coverage as defined in section 2791 of the Public Health Service Act and are not eligible for Medicaid. No FFP is available for any members of this group who have Medicare or other insurance.

ICHIP Benefits/Cost Sharing: For those individuals included in the ICHIP program, the State will provide inpatient, outpatient, physician's surgical and medical services, laboratory and x-ray services, and pharmacy services. Coinsurance is 20% for preferred providers and 40% for other providers. (note: A more detailed list of benefits, similar to those available under MCHA, is included in an appendix to the Illinois waiver application.)

Conclusions: After reviewing both the MCHA and ICHIP programs several things are clear:

1. The Montana Comprehensive Health Authority program and the Illinois Comprehensive Health Insurance Program were created for the same purpose, to provide last resort health care coverage to citizens who are uninsurable in the regular health insurance market due to their medical conditions, many of whom have low incomes;

2.While there are some differences in the way the monies are distributed, both programs receive some direct support through an appropriation of state funds;

3. Illinois has already secured approval for a HIFA Waiver, one component of which enables them to access federal funding for health care benefits provided to some low income ICHIP participants; and then used the general fund savings from ICHIP to fund additional health care benefits to other low income uninsured citizens of Illinois;

4. The Montana Department of Public Health and Human Services is in the process of developing a HIFA Waiver proposal to submit to the 2005 Legislature that does not include the possibility of securing federal funding for some portion of MCHA benefits.

Recommendation: DPHHS and the State Auditor's Office should jointly explore the potential of expanding the scope of the Montana HIFA Waiver proposal to secure federal funding for health care benefits provided to low income MCHA participants and reinvesting any savings to expand or enhance MHSP and/or provide some form of health care coverage for a group of currently uninsured low income Montanans.